

The Hesitator



**Empowering medical professionals
to act decisively in critical
moments**



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How to Overcome Hesitation in Clinical Decision-Making

As a clinician, you often find yourself second-guessing decisions, particularly when faced with high-pressure situations. This is perfectly natural, especially for those of us who want to make the right choice for every patient. However, hesitation in emergency care can lead to delayed action, resulting in potentially dangerous outcomes.

In my experience working in emergency medicine, the hesitation to act is common but costly. It leads to missed opportunities, increased patient anxiety, and sometimes, deteriorating clinical situations. The key is to make decisions confidently, even when the outcome is not 100% clear.

Section 1: Understanding Hesitation

Hesitation in decision-making often stems from the desire to gather more data, seek second opinions, or avoid making a mistake. While caution is important, excessive hesitation can be detrimental in emergency care.

As a Hesitator, you might find that:

- You **overanalyse** the available information, weighing every option to the point of indecision.
- You struggle with **uncertainty**, especially when you don't have a clear-cut answer.
- You may fear the **consequences** of acting too quickly or too confidently.

These patterns are often rooted in a desire for certainty—something that's difficult to achieve in the emergency setting. The truth is, clinical decisions often need to be made despite uncertainty, and the failure to act quickly can be just as dangerous as the wrong decision.

Section 2: Practical Steps to Gain Confidence in Decision-Making

Here's how you can start overcoming hesitation and make decisions with more confidence:



1. Set Clear Time Limits:

In high-pressure situations, **time is of the essence**. Set **mental time limits** for decision-making, allowing yourself a set period (e.g., 3–5 minutes) to decide. This will push you to focus on the most important information.

2. Embrace Imperfection:

In emergency medicine, the **perfect answer** rarely exists. **“Good enough” is often sufficient**, especially when action is required now to prevent patient deterioration. Don't wait for the perfect answer—**act with the best available information**.

3. Trust Your Clinical Judgment:

Over time, you've built a foundation of clinical knowledge. **Trust that foundation**. Often, your intuition is based on years of experience. **Allow yourself to make decisions confidently** even when full clarity isn't possible.

4. Use Structured Frameworks:

Frameworks like **ABCDE prioritisation** can help you quickly identify what needs to be addressed first. The **RADIAL framework** provides a structure that focuses on **recognising instability, prioritising physiology, and acting quickly**—without being paralyzed by uncertainty.

5. Limit Your Options:

A common mistake is trying to consider **too many possibilities** at once. Instead, **narrow down your choices** to two or three and focus on those. This helps to avoid being overwhelmed and reduces the cognitive burden.

Section 3: A Quick Win — Apply to a Clinical Case

Case Study: The Older Trauma Patient Who “Just Fell”

You are asked to assess an 82-year-old woman in the emergency department.

She has fallen at home and presents with

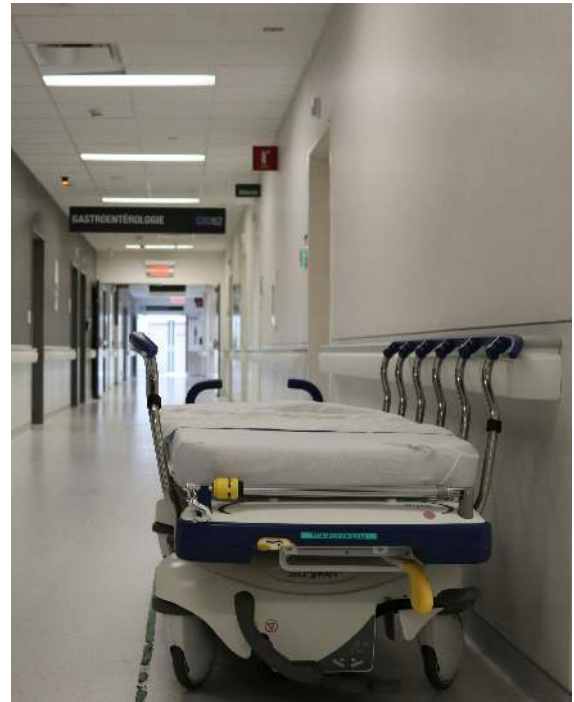
- Left hip pain
- Unable to weight bear
- Shortened, externally rotated left leg
- Heart rate 108
- Blood pressure 106/64
- Respiratory rate 22
- Oxygen saturations 96% on air
- Temperature 36.1 C
- Takes apixaban for atrial fibrillation

The paramedic handover is:

“Likely fractured neck of femur. She was on the floor for about six hours.”

Your immediate focus may be the hip fracture.

But as a Hesitator, you may feel pulled towards delay before acting decisively.



You may want to:

- Wait for the X-ray before giving stronger analgesia
- Wait for blood results before fluids
- Wait for a senior review before escalating concern
- Focus only on the obvious injury
- Reassure yourself that the observations are “not too bad”

That caution is understandable

But in older trauma patients, deterioration can be subtle.

The visible injury may not be the only risk.

Before waiting for certainty, apply the RADIAL framework.

RADIAL Framework

- **R — Recognise Instability:**
Stable vs unstable?.
- **A — ABCDE Prioritisation:**
What kills first?
- **D — Define Worst-Case Risk:**
What can't be missed?
- **I — Identify Contradictions:**
What doesn't fit?
- **A — Act & Escalate:**
What needs action now?
- **L — Loop Reassess:**
What has changed?

RADIAL Case Breakdown

R - Recognise Instability

This patient is not peri-arrest.

But she is physiologically vulnerable.

Her heart rate is raised.

Her blood pressure is borderline.

Her respiratory rate is raised.

She has been on the floor for six hours.

She is anticoagulated.

She has a likely major fracture.

These are not reassuring features.

In older trauma patients, “stable” can be misleading.

Clinical step: Do not let the phrase “mechanical fall” or “just a hip fracture” reduce your concern.

Key question: Is this patient genuinely stable, or compensating with limited physiological reserve?

A - ABCDE Prioritisation

Even when the injury appears obvious, start with ABCDE.

Clinical priorities:

- Confirm airway is patent
- Assess breathing and oxygenation
- Check circulation, perfusion and bleeding risk
- Assess conscious level
- Check glucose if reduced responsiveness or frailty concerns
- Expose appropriately to look for other injuries
- Maintain dignity and temperature control

This prevents the obvious fracture from becoming the only focus.

Clinical step: Use ABCDE before narrowing to the orthopaedic diagnosis.

The hip may be the obvious problem, but physiology decides urgency.

D - Define Worst-Case Risk

The worst-case risks are not limited to the fracture.

In this case, dangerous possibilities include:

- Occult bleeding
- Head injury while anticoagulated
- Pelvic or additional fracture
- Rhabdomyolysis after long lie
- Hypothermia
- Delirium
- Sepsis or medical cause for the fall
- Acute coronary syndrome or arrhythmia causing collapse

You do not need to prove all of these immediately.

But you do need to decide what cannot be missed.

Clinical step: Name the risks that would change immediate management.

For this patient:

1. Anticoagulated head injury
2. Occult bleeding or shock
3. Complications of long lie

This prevents hesitation caused by waiting for the full picture.

I - Identify Contradictions

Now ask:

What does not fit with “just a hip fracture”?

Possible contradictions:

- Borderline blood pressure
- Tachycardia despite lying still
- Raised respiratory rate
- Long lie
- Anticoagulation
- Unclear reason for fall
- Confusion or reduced recall
- Pain out of proportion
- Other bruising, tenderness or deformity



In this case, the mechanism may sound simple, but the risk profile is not simple.

Clinical step: Use contradictions to widen safety, not to delay action.

The aim is not to over-investigate everything.

The aim is to avoid missing the risks hidden behind the obvious injury.

A - Act & Escalate

The next safe actions may include:

- Give appropriate early analgesia
- Request hip and pelvis imaging
- Consider CT head depending on head injury history, anticoagulation and local guidance
- Check bloods, renal function and CK if long lie is significant
- Establish IV access
- Consider cautious fluids if clinically indicated
- Check ECG if collapse or unclear fall mechanism
- Keep warm and prevent pressure injury
- Escalate early to senior ED / orthopaedic / frailty teams as appropriate

The key is not to wait passively for certainty.

The key is to act on visible risk while continuing assessment.

Clinical step: Do not wait for every result before making the patient safer.

L - Loop and Reassess

After initial treatment, reassess.

Has the pain improved?

Has the heart rate settled?

Is the blood pressure stable?

Is the patient becoming more confused?

Has a hidden injury become apparent?

Have blood results changed the risk?

Has the story of the fall changed?

If new information appears, restart the loop.

Clinical step: A trauma diagnosis is not complete once the fracture is found.

Reassessment is what prevents the obvious injury from hiding the dangerous one.



Key Learning

By using RADIAL, you did not abandon caution.

You gave it structure.

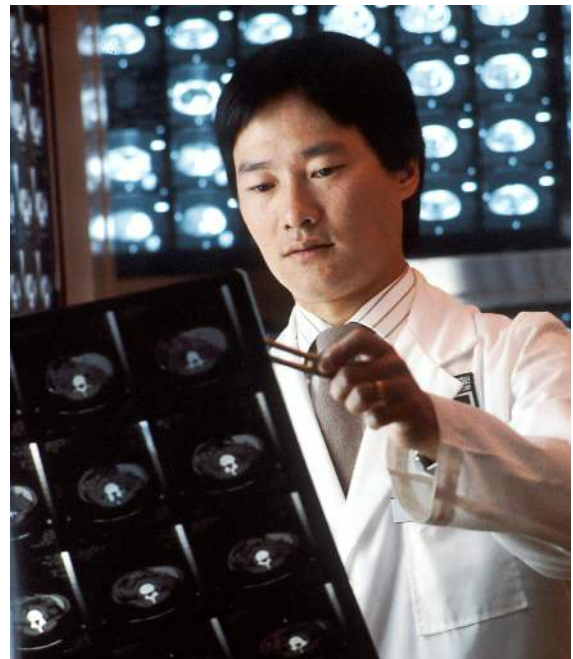
You moved from:

“I need to wait for the X-ray and results before acting.”

To:

“This patient has enough visible risk to justify action now, while I continue to reassess.”

That is the core skill for the Hesitator.



The RADIAL Clinical Thinking Playbook

A structured clinical thinking loop for recognising risk, prioritising decisions, and acting safely under pressure.

Call to Action

The RADIAL Clinical Thinking Playbook is the next step.

It gives you a practical framework to recognise instability, prioritise risk, identify contradictions, act safely, and reassess as the situation evolves

Final Line

When you are waiting for certainty, pause.

Ask whether the patient is already showing risk.

Run the loop.

